Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Hergest Unit

Ysbyty Gwynedd

Betsi Cadwaladr University Health Board

Inspection date: 15, 16 and 17 May 2023

Publication date: 22 September 2023

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Digital ISBN 978-1-83504-478-0

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Hergest Unit, Ysbyty Gwynedd, Betsi Cadwaladr University Health Board on 15, 16 and 17 May 2023. The following hospital wards were reviewed during this inspection:

- Aneurin - Female acute mental health admission ward
- Cynan - Male acute mental health admission ward
- Taliesin - Psychiatric Intensive Care Unit (PICU).

Our team for the inspection comprised of two HIW Healthcare Inspectors, four clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff interacted and engaged with patients appropriately and with dignity and respect. The majority of patients who we spoke to during the inspection and who completed our questionnaire confirmed that staff were polite, supportive, and helpful. Patients had their own programme of care that reflected their individual needs and risks. However, we found a lack of dedicated therapeutic patient activity programmes in place for patients and noted there were Occupational Therapist (OT) staffing vacancies on the unit. Satisfactory arrangements were in place to promote and protect patient rights but we found that the dormitory sleeping arrangements for patients compromised their privacy, dignity and safety.

This is what we recommend the service can improve:

- The health board must implement a formal process which ensures that patient, family and carer feedback is routinely captured, documented and acted upon as necessary
- The health board must make continued efforts to recruit to vacant OT posts to ensure the provision of meaningful therapeutic activities for patients
- The health board must develop a comprehensive therapeutic activity timetable for patients which includes activities on evenings and weekends
- The health board must ensure that patients can access functional equipment and facilities which encourage health promotion and improvement
- The health board must consider opportunities for single person accommodation to improve the patient experience on the unit.

This is what the service did well:

- Unit staff were strongly encouraged and supported to complete Welsh language training.

Delivery of Safe and Effective Care

Overall summary:

Patient care plans were being maintained to a good standard. We generally found suitable protocols in place to manage risk, health and safety and infection control. The statutory documentation we saw verified that the patients were legally

detained. We were assured at the time of our visit that there were sufficient staff numbers to provide safe and appropriate patient care but many staff members voiced concerns that patients could no longer access dedicated inpatient psychology or consultant support on the unit. Staff appeared committed to providing safe and effective care but some patients told in our survey that they felt unsafe from other patients and staff. One of the reasons given for this was because restricted items were sometimes being brought onto the ward by patients, which posed a safety risk onto the wards. The unit's paper records were generally well-organised and well-completed but some improvements were required to ensure the full completion of documentation including clinic room temperature checks, Positive Behaviour Support plans and medication records. Staff expressed that their working practices would be improved with the introduction of an electronic health record system.

This is what we recommend the service can improve:

- The health board must review its existing policies and procedures with a view to making any additional improvements which can prevent restricted items being brought into the ward to ensure the safety of patients, staff and visitors
- The health board must ensure that the unit washing machines are fully functional and fit for purpose. The health board should consider providing additional washing machines to support the number of patients on the unit
- The health board must ensure that Medication Administration Records are fully completed to include patient legal status information. Additional training should be provided to ensure that medical staff understand their role and responsibilities when completing the charts
- The health board must undertake robust measures to recruit to vacant consultant and psychology posts on the unit to ensure the provision of effective care for patients.

This is what the service did well:

- The unit's Mental Health Act team showed a high level of competence, organisation and efficiency and had a good relationship with external agencies.

Quality of Management and Leadership

Overall summary:

The majority of staff who completed HIW questionnaires provided positive feedback about working on the unit. We saw evidence of good collaborative working across the health board to support improvements and disseminate quick

learning from incidents and serious untoward events. Established governance arrangements were in place to provide oversight of clinical and operational issues. The leadership team was approachable and supportive to staff and had a good understanding of patient needs but there was no formal staff meeting process to engage staff, discuss issues and encourage staff feedback. Most staff told us they felt there were not enough staff on the wards to enable them to do their job properly and we noted that there were a high number of staff vacancies at the time of our inspection. We saw evidence that staff who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training had been involved in patient restraints but were assured that all unit staff would be fully compliant with their training by September 2023.

This is what we recommend the service can improve:

- This health board must consider ways of retaining and developing existing staff members on the unit in order to ensure the stability and expertise of the workforce
- The health board must actively focus on the recruitment of staff into outstanding permanent vacancies on the unit
- The health board must conduct a review of staff mandatory training compliance to ensure that all outstanding mandatory training is completed, regularly monitored and that staff are supported to attend the training
- The health board must implement a formal staff meeting process to obtain staff feedback and strengthen staff working relationships.

This is what the service did well:

- We were informed there had been improvements in the culture, morale and working conditions for staff since our last inspection of the setting.

3. What we found

Quality of Patient Experience

We invited patients, family and carers to complete HIW questionnaires to obtain their views on the service provided at the hospital. In total, we only received seven completed patient questionnaires and one family/carer questionnaire, which means it is challenging to draw clear themes given there were 40 patients on the unit at the time of the inspection. However, of those who contributed the responses were generally negative across all areas. Some patients stated that they do not feel safe on the unit, citing other patients and staff members as the main reasons for feeling unsafe. We did not identify a common cause for this, but one reason given was other patients bringing restricted items onto the ward, which is explored later in the report. Despite these responses, most still felt that the service provided by the hospital was 'good' or 'very good.' Some of the questionnaire results appear throughout this report.

Patient Feedback

The health board had a process in place where patients could escalate concerns via the health board's Putting Things Right complaints procedure. Senior ward staff on all wards confirmed that wherever possible they would try to resolve complaints immediately and share learning from incidents appropriately.

Four of the six staff members who completed our online survey agreed that patient experience feedback was collected but only two agreed that they received updates on patient experience feedback. Half of the staff who completed our online survey stated that feedback from patients was used to make informed decisions on the unit. However, during our inspection we did not find evidence that patients, family and carers could engage and provide feedback on the provision of care. We were told that there was no formal process in place to obtain patient or family carer feedback on the unit. We saw no evidence of processes which ensured that patients received feedback to any complaints or suggestions they made. There were no 'you said we did boards' on display on the wards. In view of the negative responses to our patient survey, it is important for the health board to take clear steps to engage better with patients, capturing their feedback regularly.

The health board must implement a formal process which ensures that patient, family and carer feedback is routinely captured, documented and acted upon as necessary.

Person centred

Health Promotion

We looked at a sample of patient records and saw evidence that patients received appropriate physical assessments upon their admission in addition to their mental healthcare. Patients had physical health care plans which documented any required ongoing health promotion and preventative interventions, such as dietician support and access to GPs.

During the tour of the unit we noted there was no health promotion and improvement information displayed on the wards for patient awareness. Smoking cessation was offered and recorded in individual patient records but we witnessed patients smoking in the communal garden areas, which contravenes current Welsh Government guidelines. Staff told us that the overall responsibility to enforce the smoking ban was placed on ward staff which adversely affected their therapeutic relationship with patients.

The health board must provide additional support for staff and patients to ensure that the unit abides to current Welsh Government smoking legislation.

There were lounge areas on the wards which offered self-directed activities such as a TV, board games and books. Each ward had an outside garden area for patient use. We found that the ward gardens were fit for purpose but required some general maintenance to make them more pleasant and appealing. The unit had a large activities room which was located in a secure area unconnected to the three wards. We were told that the activities room was available to the patients of all three wards but the room was rarely used as there were no dedicated staff available to support and supervise off-ward patient activities. The gym equipment was also cordoned off for the same reason. Some patients told us they were not allowed to use the facilities and complained that some of the musical instruments in the room were broken. Therefore, we were not assured that patients were supported to maintain and improve their health, wellbeing and independence.

Many staff and patients expressed concerns about the lack of therapeutic activities available to patients on the unit. Most patients who we spoke to during the inspection and who completed a HIW questionnaire strongly disagreed that there were sufficient and appropriate leisure facilities available to patients. We found no evidence of dedicated therapeutic patient activity programmes on the wards. Senior staff whom we spoke with during the inspection advised that there was just one Occupational Therapist (OT) and one OT technician covering all three wards and there were staffing vacancies for one activity coordinator and one OT support worker on the unit. Existing OT staff members worked on a 9am to 5pm basis and there were no patient activities outside of these times. It was positive to note that

some nursing staff had proactively arranged some ward-based patient therapeutic activities in the absence of sufficient OT staff. However, they told us that it was difficult to provide these activities in addition to their nursing duties.

We recommend the following improvements in respect of health promotion:

- **The ward communal gardens areas must be tidied and maintained to make them more pleasant and appealing**
- **The health board must make continued efforts to recruit to vacant OT posts to ensure the provision of meaningful therapeutic activities for patients**
- **The health board must develop a comprehensive therapeutic activity timetable for patients which includes activities on evenings and weekends**
- **The health board must ensure that patients can access functional equipment and facilities which encourage health promotion and improvement.**

Dignified and Respectful Care
Throughout the inspection we observed all staff treating patients with dignity and respect. The majority of patients who we spoke to during the inspection and who completed our questionnaire confirmed that staff were polite, supportive, and helpful. The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed staff taking time to speak with patients and address any needs or concerns they raised, which demonstrated that staff had responsive and caring attitudes towards the patients.

It was positive to note that the six patients on Taliesin had their own rooms which maintained their privacy and dignity. However, the sleeping arrangements for the seventeen patients on Cynan and Aneurin consisted of five individual patient bedrooms and three four-bedded patient dormitories with beds separated by curtains. We found that this arrangement compromised patient privacy and dignity during their stay.

We recommend that the health board should consider opportunities for single person accommodation to improve the patient experience on the unit.

During our tour of the unit we noted that there were limited toilet and washing facilities for the patients on the wards. There were two ensuite patient bedrooms within the unit and all other patients used communal bathrooms. We noted that there were only two communal bathrooms on Cynan and Aneurin wards which provided limited opportunities for personal care.

We recommend that the health board should consider providing additional bathroom facilities to improve the patient experience on the unit.

Patient information

We found limited information displayed to help patients and their families understand their care. We saw some patient information displayed in the foyer area of the unit including a Putting Things Right leaflet which signposted patients to the complaints process. However, there was no information displayed about the role of HIW and how patients can contact the organisation as required by the Mental Health Act 1983 Code of Practice for Wales. There was no information regarding the Mental Health Act nor advocacy displayed on the unit. There were no staff organisational charts displayed for the information of patients and visitors.

We found no patient information displayed on any of the wards. We discussed this matter with staff who advised that the existing patient information had been removed due to recent redecoration of the unit but would be returned in due course.

The health board must ensure that relevant and up to date patient, family and carer information is displayed in the communal areas of the wards.

Individualised care

We reviewed the Care and Treatment Plans (CTPs) of eight patients across the three wards. The plans were person centred and each patient had a programme of care that reflected the needs and risks of the individual patients. More findings on the Care and Treatment Plans can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

On all wards we found that patients were supported to make their own decisions wherever possible. We observed patients making their own food and clothing choices. Patients were supported to carry out every day personal tasks to promote independence which included attending to personal hygiene, cleaning their own rooms and using the laundry room whilst supervised. Most patients who completed a HIW questionnaire told us they had taken escorted leave since becoming a patient on the unit.

Patients could personalise their rooms and store personal items as they wished. Rooms were also available for patients to spend time away from other patients according to their needs and wishes. The unit had a visitor's room where patients could see their families in private. Most patients who completed our questionnaire told us they had had contact with friends or family within the past month.

Timely

Timely Care

We found strong evidence that patients were regularly monitored and received timely care in accordance with individual and clinical need. There were various meetings and processes that supported the timely and effective care of patients. The wards held daily acute care management and twice daily safety huddle meetings to establish bed occupancy levels and to discuss patient care needs. Staff also attended regular multidisciplinary meetings to share information and discuss individual patient cases.

Equitable

Communication and language

We witnessed staff treating patients with respect and kindness throughout the inspection. Patients appeared confident in approaching staff to engage in discussions. There were suitable areas where patients could speak privately with staff if required.

The unit used digital technology as a tool to support effective communication by way of online meetings and electronic information sharing in order to ensure timely patient care. Some patients had access to their own mobile phones based on individual risk assessment. Patients were also provided with access to the internet which was monitored and restricted to ensure their safety. Hospital electronic devices were available for patient use but we were told that the communal iPad on Aneurin had been removed from the unit for an extended period of time and no replacement iPad had been provided to the ward.

The health board must ensure the provision of sufficient communal electronic devices for patient use on the unit.

We found that unit staff were strongly encouraged to complete Welsh language training. Welsh speaking staff members were identified by uniform and we witnessed staff members speaking to patients in Welsh during the inspection. Staff showed understanding of the importance of speaking with patients in their preferred language and outlined an example of how this had defused an incident of challenging patient behaviour which would otherwise have resulted in the use of restrictive practices.

Rights and Equality

We reviewed seven patient records of individuals that had been detained under the Mental Health Act. The legal documentation we reviewed was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of

Practice for Wales (the Code). Further information on our findings on the legal documentation is detailed in the Mental Health Act Monitoring section of this report.

We found satisfactory arrangements in place to promote and protect patient rights. Overall staff compliance with mandatory Equality, Diversity and Human Rights training was 93 per cent on the unit. The unit had established policies to help ensure that the patients' equality and diversity were respected, and their human rights maintained. Reasonable adjustments were in place so that everyone could access and use services on an equal basis Staff showed suitable regard for upholding patient rights and provided examples which evidenced their respect for individual patient preferences.

Regular ward meetings were held to review and discuss practices to minimise the restrictions on patients based on individual patient risks. Patient care was consistent in accordance with the patient age group and requirements. We were assured that patients had access to a mental health advocate who can provide information and support to patients with any issues they may have regarding their care.

Delivery of Safe and Effective Care

Safe

Risk management
Overall, we were assured that the service had processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors. However, there is a need to strengthen arrangements to prevent patients from brining restricted items onto the wards.

We found a range of up-to-date health and safety policies were available for staff. There were established processes and audits in place to manage risk and health and safety, which enabled staff to continue to provide safe and clinically effective care.

The unit entrances were secured throughout the inspection to prevent unauthorised access. Staff wore personal alarms which they could use to call for assistance if required. We were assured that there were sufficient personal alarms for all staff, including bank and agency staff working on the wards. There were also nurse call points within dormitories and individual patient bedrooms so that patients could summon assistance if required.

Each ward provided a clean and comfortable environment for patients and the environment was generally equipped with suitable furniture, fixtures and fittings for the patient group. Ligature cutters were appropriately stored for use in the event of a self-harm emergency and we found up-to-date ligature point risk assessments in place. However, we were advised that two of the chairs in the main patient lounge on Taliesin had been assessed as a ligature risk but were still present in the lounge. We raised this issue to staff during the inspection and advised that the chairs must be removed to ensure patient safety.

The health board must remove or replace any furniture, fixtures or fittings which are deemed to be a ligature risk to ensure patient safety.

During the inspection we noted that the safety glass in the sluice room door of Taliesin ward had been replaced with perspex which posed a fire risk. We escalated this matter to senior staff and the risk was satisfactorily addressed during the inspection.

We were generally assured that patients were receiving safe and effective care on the unit. We were not able to obtain feedback from all patients during our visit, however, some patients whom we spoke with during the inspection and five of the

seven patients who completed our questionnaire told us they felt unsafe. Whilst there was not a common reason given for why they felt this way, most stated they felt unsafe due to other patients, with two patients telling us they felt unsafe due to other patients and staff. In particular, one patient provided an example of a recent incident when a fellow patient had self-harmed with a lighter brought onto the ward by another patient. They expressed concerns that staff were unable to prevent patients from bringing lighters on to the ward.

Patients we spoke to during the inspection told us that it was possible to bring restricted items onto the ward despite being searched by staff. We discussed this matter with staff who confirmed that patients and their belongings were routinely searched upon their arrival at the unit or upon their return from leave. Staff advised that additional scrutiny was placed on patients bringing restricted items onto the wards but it was not always possible to prevent this from happening on an informal ward. In accordance with the health board's policy for detained patients, we were told that informal patients could enter or request to leave the hospital when they wished to, subject to the necessary risk assessments. Staff acknowledged that there were instances when patients had brought restricted items onto the ward which had not been found during searches.

The health board must review its existing policies and procedures with a view to making any additional improvements which can prevent restricted items being brought into the ward, to ensure the safety of patients, staff and visitors.

Infection prevention and control (IPC) and decontamination
We found suitable IPC arrangements in place. A range of up-to-date policies were available that detailed the various IPC procedures to keep staff and patients safe. Regular audits had been completed to check the cleanliness of the environment and monitor compliance with hospital procedures. The training statistics provided by the hospital evidenced a high level of staff compliance with IPC training at 93 per cent and 86 per cent for levels 1 and 2.

The environment of both wards and the wider hospital was clean and uncluttered. Decorative measures had been undertaken and were ongoing at the time of our inspection. Cleaning schedules were in place to promote regular and effective cleaning of the wards. We found dedicated cleaning roles and responsibilities across domestic and nursing staff carried out to good effect.

We generally found the unit's furniture, fixtures and fixings to be in a good state of repair. However, during our tour of the unit we viewed the Section 136 suite and noted several issues which required improvement as follows:

- **There were holes in the sofas which presented as an IPC risk. They should be repaired or replaced**
- **There were stains on the ceiling and wall which should be cleaned to ensure appropriate IPC**
- **There was a large hole in the Section 136 monitoring room chair which should be repaired or replaced.**

We reviewed the laundry facilities on the wards and noted there was one washing machine on each ward. We were advised that the washing machines were not industrial machines and regularly broke down which resulted in staff washing patient clothing on other wards. This issue created additional work for staff and prevented them from performing their nursing duties.

The health board must ensure that the unit washing machines are fully functional and fit for purpose. The health board should consider providing additional washing machines to support the number of patients on the unit.

Safeguarding children and adults
A comprehensive safeguarding policy was in place and up to date. The unit had an appointed safeguarding representative. There were established hospital policies and processes in place to ensure that staff safeguarded vulnerable adults, with referrals to external agencies as and when required. Staff had access to the hospital's safeguarding procedures and showed awareness of the process of making a safeguarding referral. We saw evidence that safeguarding concerns were recorded and addressed appropriately in line with policy.

We viewed minutes of multidisciplinary team (MDT) and Clinical Governance meetings which evidenced that safeguarding was discussed as a standing agenda item to help identify any themes and lessons learned. Putting Things Right and Quality, Safety and Experience meetings took place to share concerns and learning opportunities across the service. Compliance among staff with safeguarding training courses was high at over 85 per cent on all wards.

Medicines management
Relevant policies, such as medicines management and rapid tranquillisation, were in date and were available to staff electronically on computers but we noted that the review date for the Rapid Tranquilisation Protocol for use in adults had expired in March 2022.

We reviewed the unit's clinic arrangements and generally found robust procedures in place for the safe management of medicines on each ward. The clinic rooms were clean, tidy and well organised. Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse.

Medicines were securely stored within locked fridges, cupboards and the electronic dispensary system in place on the unit. The records evidenced that stock was accounted for when administered and that stock checks were being undertaken.

We found systems in place to ensure that daily checks of the clinic room equipment were being completed. However, on examining the clinic room audits we identified a number of gaps in the blood monitoring chart and were advised that these checks were not always conducted due to staff not having received the relevant training to do so.

Staff must be provided with the relevant training to ensure the blood management checks are routinely conducted.

There was evidence of regular temperature checks of the medication fridges to monitor that medication was stored at the manufacturer's advised temperature. However, we noted gaps in the medicines refrigerator monitoring forms when no checks had been conducted on several dates. We further saw recorded instances when the clinic room and medicines refrigerator temperatures had exceeded recommended guidelines but there was no evidence that staff had followed the correct procedure to escalate the matter as per guidance. This was also an issue we identified during our previous inspection of the setting in 2021.

The health board must ensure that robust measures are implemented to ensure the relevant clinic room checks are conducted and documented. Instances when the clinic room and medicines refrigerator temperatures fall outside recommended guidelines must be escalated to ensure medication is stored at the correct temperature.

We viewed a sample of Medication Administration Records (MAR charts) and generally found they were completed and maintained to a good standard. There was evidence of regular medication reviews completed during weekly ward rounds with direct input from the unit’s dedicated mental health pharmacist. We observed sensitive and appropriate prescribing of medication in accordance with patient needs. We found a comprehensive programme of ward-based audit conducted by nursing and pharmacy staff which supported the safe administration of medication.

However, we found that the MHA legal status section of the MAR charts was consistently left blank on all wards. Therefore, we were not assured that medical staff were compliant with the legal requirements for MAR chart completion which require that MHA information and corresponding consent to treatment dates must be completed on all charts. We advised staff that the absence of legal status

information could result in a lack of clear guidance for staff administering patient medications.

The health board must ensure that MAR charts are fully completed to include patient legal status information. Additional training should be provided to ensure that medical staff understand their role and responsibilities when completing the charts.

We noted that improvements were required in respect of the filing arrangements of the MAR charts. We found that the documents were stored as loose copies which could easily become lost or disorganised, rather than within a dedicated filing system.

The heath board must implement a dedicated filing system which supports the safe storage and navigation of the MAR charts.

Challenging behaviour

We were assured that staff responded to patient needs in a timely manner and alternative options and explanations were provided when they could not be met. It was positive to find that the unit had recently commenced the use of 'safe wards' as a preventative measure. Principles of positive behavioural support were also being used as a method of de-escalation to manage challenging behaviour. However, we noted that the Positive Behaviour Support plans (PBS) of some patients were left blank within their records.

PBS plans must be regularly reviewed, updated to reflect the current needs of patients and made accessible to all staff.

During the inspection we noted that the unit's dormitory accommodation arrangements provided limited spaces where patients could retreat to as a method of reducing or preventing challenging behaviour. We noted instances where increased levels of therapeutic observation were required to manage the interpersonal difficulties and vulnerabilities of patients living in close proximity on the wards. Dormitory accommodation appeared to be a causative factor for patient incidents and for patients feeling unsafe on the unit. Staff we spoke to during the inspection told us that the unit's single bedrooms were allocated to patients with more complex mental health needs but that all patients desired a room of their own.

It was positive to note that during our conversations with staff they showed understanding of the restrictive practices available to them as well as appropriate preventative measures which can reduce the need for restrictive responses to challenging behaviour. We saw evidence of restrictive practices being used as a

last resort, with thorough monitoring around therapeutic effect and risk, and diversionary tactics in place as a method of de-escalation. Staff demonstrated that incidents of restrictive practice were appropriately recorded and monitored via individual patient care records and Restrictive Physical Intervention records.

We saw examples of good practice in place in respect of staff undertaking safe and supportive therapeutic patient observations. Staff had received additional training and a useful guide on the key principles of undertaking safe patient observations. We found patient observations were conducted and recorded in line with hospital policy.

Effective

Effective care

We found that systems and governance arrangements were in place which helped ensure that staff provided safe and clinically effective care for patients. The hospital had policies in place to help protect the safety and wellbeing of patients and staff. There was an established electronic system in place for recording, reviewing and monitoring incidents. There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that occurrence of incidents could be monitored and analysed.

We were assured that there were sufficient staff numbers to care for the patients on all wards. Staff we spoke to during the inspection reported that they felt their team worked in a professional and collaborative way. However, many staff members expressed concern that patients no longer had access to dedicated psychology support within the unit. We were told there had previously been a unit-based consultant and psychologist but psychology support for patients was now provided by community psychology services rather than a dedicated hospital inpatient psychologist. The unit's current vacancy for an inpatient psychologist was being recruited to at the time of our inspection, but staff expressed that the lack of psychology support of patients was of ongoing concern.

We were further informed that a lack of continuity regarding consultant cover on the unit resulted in delays to patients being seen by a consultant after admission. We observed instances when new patient admissions were not seen by a consultant within seventy-two hours of their arrival. We were told that family members and community teams could not be given accurate times to attend important patient meetings as unit staff could not determine when the on-call consultant would arrive. Staff outlined an example whereby a family member had waited one and a half hours for the consultant to attend an arranged meeting.

A family member who completed our questionnaire told us:

"Some staff are extremely caring and have always helped me with any enquiries. Staff seem to be doing their best but are not served well by the way the structure works here - communication from consultants down to staff is poor."

We were informed that temporary staffing measures had been implemented to address this matter and were assured that in the event of a psychiatric emergency the unit could access an on-call consultant twenty-four hours a day. However, it was clear that the interim consultant cover arrangements were not sustainable and were impacting on the quality of care provided to patients.

The health board must undertake robust measures to recruit to vacant consultant and psychology posts on the unit to ensure the provision of effective care for patients.

Patient records

We found well-organised paper records completed on the unit, which were easy to navigate through clearly marked sections. Information was being captured comprehensively within the records and they were appropriately and securely stored. However, staff advised us that the hospital's paper records system presented problems for them in respect of document completion, volume and storage. Staff expressed that their working practices would be improved with the introduction of an electronic health record system which would resolve these issues.

We recommend that the health board must review the current health record system with a view to implementing an electronic health record system in future.

Nutrition and hydration

Our examination of case notes and clinical entries found that patients were supported to meet their individual dietary needs and provided with diets in accordance with their medical needs. Patient nutritional and hydration needs were assessed, recorded and addressed. Diabetes specialist nurses were available on site for patients if required.

The wards had patient facilities where they could access food and drinks throughout the day. However, we saw instances when communal foods had been opened but did not display an opening date so the expiry date could not be determined.

We recommend that the communal food on the wards must be regularly checked and appropriately labelled to ensure patient safety.

During the inspection we observed that staff were supportive of individual patient food choices. The dining rooms were clean and tidy and provided a suitable environment for patients to eat their meals. We were told that patients could choose from the general hospital menu which rotated on a weekly basis, but they did not have any involvement in reviewing or creating the menu. Most patients told us that the hospital food was good and met their dietary requirements. However, some told us that they would like a more varied and less repetitive menu. The health board may wish to consider conducting further consultations with patients in respect of this.

Mental Health Act Monitoring

We examined seven records for patients who were detained under the Mental Health Act and found that legal documentation to detain patients under the Act was compliant with the legislation. Patients were legally detained and reliably informed of their rights under the Act. Mental Health Act files were very well organised, easy to navigate and contained detailed and relevant information.

There was good evidence of visible advocacy involvement in patient case work. We witnessed timely responses to requests for hospitals managers hearings and mental health review tribunals.

We saw examples of good practice in relation to the organisation and efficiency of the unit's Mental Health Act team and its good relationship with external agencies such as Community Mental Health Teams, Approved Mental Health Professionals and medical staff.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010. We reviewed a sample of Care and Treatment Plans (CTPs) and found that they were completed in accordance with the Mental Health (Wales) Measure 2010. The paper-based records were well organised, easy to navigate and securely stored. The care plans recorded the reasons for admission and the interventions provided by the MDT. Physical health screening was completed on admission and reviewed in accordance with health board policy. We found strong evidence that patients, family and carers had been involved in the the development of the care and treatment plans wherever possible.

Within all the records we found comprehensive assessments and risk assessments. The CTPs were person-centred and included a good level of patient specific detail.

Patients were regularly reviewed through the established ward round arrangements which included care and treatment plan reviews, risk reviews and discharge planning. MDT participation was evident across the wards and included the involvement of external agencies and community professionals where required. We saw notable examples of good practice which included the completion of dedicated care plans for therapeutic observations.

The admissions pathway provided a timeline of required interventions post admission. Within the records we observed the seventy two hour admission pathway had generally been completed to good effect. However, we saw an example on Aneurin where a patient had been admitted for over three weeks but the seventy two hour pathway had only been partially completed.

The health board must conduct a review of patient records to ensure all admissions pathway documentation is fully completed.

Quality of Management and Leadership

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total, we received six responses from staff at the setting. Staff responses were mostly positive, with five of the six respondents recommending the hospital as a place to work and confirming that they would be happy with the standard of care provided for their friends or family.

Staff comments included the following:

> *"At times, understaffing means people have to compensate and work much harder to cover and complete all tasks."*

> *"Colleagues are hard working and professional. They are dedicated to serving patients well. However, I do not sense that clinical activity is underpinned by sufficient reference to external bench-marking relating to standards and procedures. Adherence to such guidelines would require better clinical staffing across all disciplines. A sense of 'this is how we have always done it and it seems to be okay' prevails. Clinical managers in the teams are accessible and supportive. Managers higher up are invisible, to me at least. I do not know their names except from occasional emails that I may be copied into. I certainly would not recognise them in the corridor."*

We asked what could be done to improve the service. Comments included the following:

> *"There is a good culture of care within staff on the unit. Improved medical staffing (consultants) would improve patient care with more regular review."*

Leadership

Governance and leadership

It was positive to observe strong team working on the wards throughout our inspection. Staff were respectful of each other and there was a positive approach to team working with clear lines of responsibility for certain tasks. The staff members we interviewed during the inspection spoke passionately about their roles. We were told that recent recruitment and changes to the unit's staffing and leadership structure provided a more stable and supportive working environment for staff. Staff told us they felt supported in their roles and that the leadership team was approachable. However, we were told that the interim status of senior

staff members continued to create feelings of uncertainty amongst staff. The majority of staff who completed our online questionnaire agreed that senior managers were visible and half agreed that communication between senior management and staff was effective. They further agreed that their organisation encourages teamwork and was supportive and helpful to them.

We found an effective governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. Acute Care Management, Safety Huddle and Putting Things Right meetings we attended during the inspection demonstrated good collaborative working across the health board to support improvements and disseminate quick learning from incidents and serious untoward events.

Workforce

Skilled and enabled workforce

Throughout our inspection we were assured that unit staffing levels were sufficient to maintain patient safety with the support of bank and agency staff. Most staff who completed a HIW online survey agreed they were able to meet the conflicting demands on their time at work. However, staff we spoke to during our inspection and half of the staff members who completed our online questionnaire told us there were not enough staff on the wards to enable them to do their job properly. Some staff told us that there was a lack of training and development opportunities within the unit resulting in experienced nursing staff transferring or being recruited elsewhere for career development. This caused the unit to lose its most skilled and experienced staff members and the necessity to recruit and train new members of staff.

This health board must consider ways of retaining and developing existing staff members on the unit in order to ensure the stability and expertise of the workforce.

In addition to the staffing vacancies previously mentioned in this report, we were advised that there were vacancies for two registered nurses on Cynan, four registered nurses on Taliesin and five registered nurses on Aneurin. We were advised that some of the vacant posts would soon be filled by trainee nurses and there were ongoing recruitment processes in place to obtain more staff on the wards.

We recommend that the health board must actively focus on the recruitment of staff into outstanding permanent vacancies on the unit.

Senior staff confirmed there was a high use of agency staff on the unit but advised that they tried to book regular agency staff who were familiar with the unit and patients wherever possible. We were told that regular staff had requested the provision of staff overtime instead of using agency staff to cover staffing short falls. Senior staff confirmed that they felt that this request should be a consideration for the health board. The health board may wish to hold further discussions with staff in respect of this.

Training figures we reviewed during the inspection indicated that overall mandatory training compliance rates were generally high on all wards. However, we noted that overall staff compliance with moving and handling training was generally low across the wards at 71 per cent for level 1 and 23 per cent for level 2.

The health board should conduct a review of staff mandatory training compliance to ensure that all outstanding mandatory training is completed, regularly monitored and that staff are supported to attend the training.

During the inspection we reviewed Datix incidents of restraint and noted that there had been six incidents of restraint since October 2022 which involved staff who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training. At the time of our inspection we were told that overall staff compliance with RPI training was 83 per cent. We discussed this matter with senior staff and were assured that all unit staff were booked onto training courses and would be fully compliant by September 2023. We noted that staff RPI training levels were discussed during the daily safety huddle to ensure there were an appropriate number of trained staff on each ward for each shift. We were assured that there were systems in place to call for RPI trained staff responders in any emergency situation.

The health board must make continued efforts to ensure all staff are compliant with RPI training to ensure the ongoing safety of staff and patients.

Culture

People engagement, feedback and learning

There was an established system in place for dealing with concerns and recording, reviewing and monitoring incidents to help identify trends and learning opportunities. Complaints, incidents and safeguarding issues were discussed during Putting Things Right meetings, with any learning shared with all staff.

All staff who completed a HIW questionnaire agreed that they understood the Duty of Candour and their role in meeting the Duty of Candour Standards. All agreed

that the health board encourages staff to raise concerns when something has gone wrong and to share this with the patient.

A whistleblowing policy was in place should staff wish to raise any concerns about issues on the unit. Staff told us they felt confident to raise any issues and most agreed that their organisation took positive action on their health and wellbeing. We were told there were various support systems available to staff including a Wellbeing Team, Occupational Health and Trauma Risk Management. During the inspection we noted that one ward had developed their own informal staff meeting process. However, there was no dedicated formal staff meeting process to engage staff, discuss issues and encourage staff feedback.

The health board must implement a formal staff meeting process to obtain staff feedback and strengthen staff working relationships.

Information

Information governance and digital technology

We found that paper records and data were being maintained in line with GDPR legislation and securely stored in locked areas. Information was accessible to all relevant staff and there were established processes to share information with partner agencies in safe and secure way. We saw high staff compliance figures with mandatory Information Governance training on all wards.

We found that several of the health board's policies were out of date during our inspection. These included:

- Rapid Tranquilisation Protocol for use in Adults – review date March 2022
- Being Open – review date March 2023
- Physical Restraint – review date October 2022
- Seclusion and Long Term Segregation – review date February 2023
- MHLD Division Staffing Escalation Procedure – review date April 2022
- Occupational Health and Safety – review date March 2021
- Safe Recruitment and Selection Practices – review date June 2019.

The health board must review any out of date policies to support staff in their roles.

Learning, improvement and research

Quality improvement activities

During our discussions with ward staff and senior managers, we were provided with many examples where they were reviewing the provision of service on the wards

and the wider health board. Senior nursing staff conducted monthly 'walkarounds' to review the ward environment and identify areas of improvement. The Quality, Safety and Experience committee held monthly meetings to identify issues, points of learning, themes and trends. We were told that since 2021 the unit had developed a two-year plan to improve working practices for staff, particularly in relation to staff culture and the visibility of the senior leadership team. Staff confirmed that the unit had since experienced a positive cultural shift which was evidenced during our inspection.

We were advised that the health board was conducting discussions relating to rebuilding or developing the existing unit site to include improvements for patients. We were further informed that there was an ongoing plan to develop a disused ward on the site to provide care for functional older adults in future.

Whole system approach

Partnership working and development
Staff were able to describe how the service engaged with partners to provide patient care and implement developments. They told us they engaged with outside partner agencies including local authorities, General Practitioners, housing, community health services and Caniad to ensure a whole systems approach to patient care.

We were told that senior staff attended regular joint agency meetings and monthly mental health leads meetings to discuss issues and build strong working relationships. The Together for Mental Health arena provided a discussion forum for carers, community health care services and other partner agencies.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
The safety glass in the sluice room door of Taliesin ward had been replaced with Perspex.	This posed a fire risk.	We escalated this matter to senior staff during the inspection.	The risk was satisfactorily addressed during the inspection. We were informed that staff had engaged with estates colleagues and an order had been placed for replacement glass to be delivered and fitted by 24th May 2023. In the meantime a risk assessment had been completed to mitigate any potential fire risk and ensure all appliances were switched off. The room was put out of use to ensure the safety of all.

Appendix B – Immediate improvement plan

Service: Hergest Unit, Ysbyty Gwynedd

Date of inspection: 15, 16 and 17 May 2023

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No immediate assurances were issued during this inspection.				

Appendix C - Improvement plan

Service: Hergest Unit, Ysbyty Gwynedd

Date of inspection: 15, 16 and 17 May 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
There was no formal process in place to obtain patient or family carer feedback on the unit.	The health board must implement a formal process which ensures that patient, family and carer feedback is routinely captured, documented and acted upon as necessary.	Continued engagement with the health boards patient experience team to develop an engagement plan to ensure consistency of collating patient/family and carer feedback in a meaningful way.	Head of Nursing- Fiona Sera Hughes	31.08.23
We witnessed patients smoking in the garden areas, which contravenes current Welsh Government guidelines.	The health board must provide additional support for staff and patients to ensure that the unit abides to current Welsh Government smoking legislation.	Smoking cessation action plan to be reviewed and updated with a focus on training and awareness for staff. Training compliance will be reported to the MHLD Service Quality Delivery Group (SQDG) monthly meeting.	Clinical operational manager- Jonathan Morris Head of Nursing- Fiona Sera Hughes	31.08.23 30.09.23

		Current signage has been reviewed and will be updated as and when required. Smoking cessation form audit will be completed weekly.	Head of Operations- Nichaela Jones Head of Nursing- Fiona Sera Hughes	Completed- 30.05.23 Initially completed by 30.08.23
The ward gardens were fit for purpose but required some general maintenance to make them more pleasant and appealing.	The ward communal gardens areas must be tidied and maintained to make them more pleasant and appealing.	To strengthen the cycle of maintenance plan with estates and facilities. To review aesthetics of the ward with ward managers and take appropriate action	Clinical operational manager- Jonathan Morris Clinical operational manager- Jonathan Morris	31.08.23 30.07.23
There were staffing vacancies for one activity coordinator and one OT support worker on the unit.	The health board must make continued efforts to recruit to vacant OT posts to ensure the provision of meaningful therapeutic activities for patients.	The OT vacancies are actively being recruited to. Job description for activities coordinators on the unit are under review.	Head of occupational therapy (OT)- Alexis Conn Clinical operational manager- Jonathan Morris	31.10.23 31.10.23

		Activities coordinator to be actively recruited to align to the updated job description.	Acute care manager- Charlotte Ladbury	30.12.23
We found no evidence of dedicated therapeutic patient activity programmes on the wards.	The health board must develop a comprehensive therapeutic activity timetable for patients which includes activities on evenings and weekends.	The acute care manager, ward managers and the head of OT will review and develop an activity time table.	Acute care manager- Charlotte Ladbury and Head of OT- Alexis Conn	30.09.23
The activities room was rarely used as there were no dedicated staff available to support and supervise off-ward patient activities. The gym equipment and exercise machines in the activities room were cordoned off with signs forbidding their use.	The health board must ensure that patients can access functional equipment and facilities which encourage health promotion and improvement.	The acute care manager and head of OT will review and develop an activity timetable to enable access to relevant facilities/ equipment and health promotion.	Acute care manager- Charlotte Ladbury and Head of OT- Alexis Conn	30.09.23
The dormitory sleeping arrangements compromised patient privacy and dignity during their admission.	The health board must consider opportunities for single person accommodation to improve the patient experience on the unit.	An options appraisal will be completed with senior leadership team, estates and facilities to establish medium and long-term options.	Head of Operations- Nichaela Jones	31.01.24
The bathrooms provided limited opportunities for personal care.	The health board must consider providing additional bathroom facilities to improve the patient experience on the unit.	An options appraisal will be completed with senior leadership team, estates and facilities to establish medium and long-term options.	Head of Operations- Nichaela Jones	31.01.24

There was a lack of patient information on display on the wards.	The health board must ensure that relevant and up to date patient, family and carer information is displayed in the communal areas of the wards.	Patient information has been updated and is visible on the wards. This will be monitored and updated via the acute care manager.	Acute care manager- Charlotte Ladbury	Completed- 10.07.23
The communal Ipad on Aneurin had been removed from the unit for an extended period of time and no replacement ipad had been provided to the ward.	The health board must ensure the provision of sufficient communal electronic devices for patient use on the unit.	Purchase an additional Ipad for the ward and ensure the availability of alternative electronic communication devises.	Ward Manager- Tanya Gibson	31.08.23
Two of the chairs in the main patient lounge on Taliesin had been assessed as a ligature risk but were still present in the lounge.	The health board must remove or replace any furniture, fixtures or fittings which are deemed to be a ligature risk to ensure patient safety.	2 chairs have been removed. Furniture has been reviewed and furniture to be replaced and ordered through procurement processes.	Ward Manager – Rachel Woods-Roberts	31.08.23
Patients we spoke to during the inspection told us that it was possible to bring restricted items onto the ward despite being searched by staff.	The health board must review its existing policies and procedures with a view to making any additional improvements which can prevent restricted items being brought into the ward, to ensure the safety of patients, staff and visitors.	Restricted items policy to continue to be implemented by staff. This will include the utilisation of a wand to identify any metal items concealed on a person on entry to wards. Toolbox talks to continue to include restricted items policy and the number of staff trained. This will be	Head of Nursing- Fiona Sera Hughes Head of Nursing- Fiona Sera Hughes	Ongoing action 30.07.23

		monitored weekly through the area SLT and the divisional Health and Safety meeting. Training trajectory to be developed to ensure all staff are compliant. Compliance monitoring through weekly file audit that will include ensuring that the policy has been implemented. The audit outcome will be reported to SQDG meeting monthly.	Head of Nursing- Fiona Sera Hughes	Initially by 30.08.23 and then ongoing monthly
We viewed the s136 suite and noted several issues which required improvements to ensure effective IPC.	There were holes in the sofas which presented as an IPC risk. They should be repaired or replaced There were stains on the ceiling and wall which should be cleaned to ensure appropriate IPC There was a large hole in the s136 monitoring room chair which should be repaired or replaced.	Sofas removed and replaced temporarily whilst procurement process progress for replacement sofas. Domestics to complete cleaning regime after each admission to the s136 suite. Stains on wall were removed at point of inspection. Duty nurse to ensure visible inspection of the s136 on discharge of each patient.	Head of Operations- Nichaela Jones Acute care manager- Charlotte Ladbury	31.08.23 Initially completed on 17.05.23 30.07.23

		Estates to re paint ceiling. Chair in monitoring room was removed.	Estates- Owen Griffiths Head of operations - Nichaela Jones	17.05.23
The unit washing machines were not industrial and regularly broke down which resulted in staff washing patient clothing on other wards.	The health board must ensure that the unit washing machines are fully functional and fit for purpose. The health board should consider providing additional washing machines to support the number of patients on the unit.	Escalate to any issues with the function of washing machine at daily huddle. To ensure that all washing machines are to health board standards and functioning as appropriate. Options appraisal to be completed to establish if current ward based washing facilities are adequate.	Head of Operations- Nichaela Jones Acute care manager- Charlotte Ladbury Acute care manager- Charlotte Ladbury	31.08.23 30.09.23 30.09.23
We identified a number of gaps in the blood monitoring chart and were advised that these checks were not always conducted due to staff not	Staff must be provided with the relevant training to ensure the blood management checks are routinely conducted.	All staff in work to be fully compliant in blood monitoring training.	Head of Nursing- Fiona Sera Hughes	30.10.23

being having received the relevant training to do so.		Compliance of the training will be reported to SQDG meeting monthly.	Head of Nursing- Fiona Sera Hughes	Initially by 30.08.23 and then ongoing monthly
We noted gaps in the medicines refrigerator monitoring forms when no checks had been conducted. We further saw instances when the clinic room and medicines refrigerator temperatures had exceeded recommended guidelines but there was no evidence that staff had followed the correct procedure to escalate the matter as per guidance.	The health board must ensure that robust measures are implemented to ensure the relevant clinical room checks are conducted and documented. Instances when the clinic room and medicines refrigerator temperatures fall outside recommended guidelines must be escalated to ensure medication is stored at the correct temperature.	Audit on iris (a system audit) to continue to be undertaken weekly by ward managers and appropriate escalation completed. The audit outcome will be reported to service delivery and quality group (SDQG) meeting monthly. Memo to be provided outlining escalation process.	Ward managers for all three wards. Head of Nursing- Fiona Sera Hughes Acute care manager- Charlotte Ladbury	Weekly Initially by 30.08.23 and then ongoing monthly 30.07.23
The MHA legal status section of the MAR charts was consistently left blank on all wards.	The health board must ensure that MAR charts are fully completed to include patient legal status information. Additional training should be provided to ensure that medical staff understand their role and responsibilities when completing the charts.	Acute Care Manager to liaise with the lead pharmacist and ward managers to strengthen monitoring of MAR charts and support any escalation as required.	Acute care manager- Charlotte Ladbury	31.07.23

		Learning to be shared in Putting Things Right and SQDG meeting. The clinical director to ensure all current/future medical staff are aware of this requirement.	Head of Nursing- Fiona Sera Hughes Clinical director	31.08.23 31.08.23
The MAR charts were stored as loose copies which could easily become lost or disorganised, rather than within a dedicated filing system.	The heath board must implement a dedicated filing system which supports the safe storage and navigation of the MAR charts.	Acute Care Manager and the business support manager will review best practice for record keeping with lead pharmacist and ward managers to ensure compliance.	Acute care manager- Charlotte Ladbury	30.07.23
The Positive Behaviour Support plans (PBSs) of some patients were left blank within their records.	PBS plans must be regularly reviewed, updated to reflect the current needs of patients and made accessible to all staff.	Weekly file audit to be undertaken. The audit outcome will be reported to SQDG meeting monthly.	Head of Nursing- Fiona Sera Hughes	Initially by 30.08.23 and then ongoing monthly
Patients no longer had access to dedicated consultant and psychology support on the unit.	The health board must undertake robust measures to recruit to vacant consultant and psychology posts on the unit to ensure the provision of effective care for patients.	Recruitment plan in place for psychology. Recruitment plan in place for Consultant Psychiatrists.	Head of psychology- Dawn Henderson Clinical Director – Dr Pritpal Singh.	30.11.23 01.01.24
Staff expressed that their working practices would be	The health board should review the current health record system with a	The Welsh Community Care Information System (WCCIS) is	Head of Informatics,	31.03.24

improved with the introduction of an electronic health record system.	view to implementing an electronic health record system in future.	the electronic patient record for inpatient mental health, a non-mental health pilot has started in Ynys Mon and the full roll out dates will be agreed.	Programmes, Assurance and Improvement – Andrea Williams	
We saw instances when communal foods had been opened but did not display an opening date so the expiry date could not be determined.	The communal food on the wards must be regularly checked and appropriately labelled to ensure patient safety.	The ward managers to ensure food hygiene principles are fully implemented at all times. Kitchen audits to be undertaken in line with Policy. The audit outcome will be reported to SQDG.	Ward managers Acute care manager- Charlotte Ladbury & Head of Nursing- Fiona Sera Hughes	31.08.23 Initially by 30.08.23 and then ongoing monthly
We saw an example on Aneurin where a patient had been admitted for over three weeks but the seventy-two-hour pathway had only been partially completed.	The health board must conduct a review of patient records to ensure all admissions pathway documentation is fully completed.	Compliance monitoring through weekly file audit.	Head of Nursing- Fiona Sera Hughes	Initially by 30.08.23 and then ongoing monthly
Some staff told us that there was a lack of training and development opportunities within the unit resulting in experienced nursing staff transferring or being recruited	This health board must consider ways of retaining and developing existing staff members on the unit to ensure the stability and expertise of the workforce.	Initial Training Needs Analysis has been completed in April 23 that includes all mandatory training.	Head of Operations- Nichaela Jones	Initially completed April 23 30.10.23

elsewhere for career development.		Head of nursing to work with acute care manger and ward managers to scope additional training requirements for ward staff. All training available to continue to be shared with all staff in west. To identify opportunities for development of staff via PADR's and share training opportunities with the whole staff team.	Head of Nursing- Fiona Sera Hughes Head of Nursing- Fiona Sera Hughes Head of Nursing- Fiona Sera Hughes	As received. As per meeting dates.
There were vacancies for two registered nurses on Cynan, four registered nurses on Taliesin and five registered nurses on Aneurin.	The health board should actively focus on the recruitment of staff into outstanding permanent vacancies on the unit.	Head of nursing to support oversea nurse recruitment and posts for streamlining. Continue to actively recruit to vacant posts. Consider skill mix review for Unit. Continue with block booking of regular bank and agency staff as required.	Head of Nursing- Fiona Sera Hughes	Continual action until all posts recruited to. Majority of posts should be appointed by Sept 23

Staff compliance with moving and handling training was generally low across the wards at 71 per cent for level 1 and 23 per cent for level 2.	The health board must conduct a review of staff mandatory training compliance to ensure that all outstanding mandatory training is completed, regularly monitored and that staff are supported to attend the training.	Head of nursing and manual handling team to support bespoke manual handling training. Level 2 plan to be developed and implemented. Mandatory training compliance to be reported to the monthly West area and monthly divisional Finance and performance meeting for action.	Head of Nursing- Fiona Sera Hughes Head of Operations- Nichaela Jones	30.9.23 Monthly
We reviewed Datix incidents of restraint and noted that there had been six incidents of restraint since October 2022 which involved staff who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training.	The health board must make continued efforts to ensure all staff are compliant with RPI training in order to ensure the ongoing safety of staff and patients.	Total RPI compliance – 83.6% Staff who require training in RPI have been booked on to receive training with expected full compliance by the end of October 23 for all staff who are in work.	Head of Nursing- Fiona Sera Hughes	31.10.23
There was no dedicated formal staff meeting process to engage staff, discuss issues and encourage staff feedback.	The health board must implement a formal staff meeting process to obtain staff feedback and strengthen staff working relationships.	Team meeting schedule to be strengthened to ensure staff feedback is captured at ward level.	Head of Nursing- Fiona Sera Hughes	30.07.23

Several of the health board's policies were out of date.	The health board must review any out-dated policies which are past review dates. It is important that policies and procedures are kept up to date and reviewed to support staff in their roles.	The Mental Health and Learning Disability policy group to continue to progress the review and update of MHLD specific policies. Organisational Policy (generic) to be progressed by relevant Policy Leads.	Head of Governance – Fran Moore Secretary for the Board.	31.12.23 31.12.23

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative
Name (print): Mike Smith
Job role: Director of Nursing
Date: 13.07.2023